EXHIBIT 31

NEVADA PRESCRIPTION DRUG POLICY MAKERS SUMMIT

NEVADA PRESCRIPTION AFFORDABILITY ACHIEVEMENTS AND ONGOING REFORMS BACKGROUND PAPER SEPTEMBER 22, 2005

This paper will present the major initiatives regarding efforts to make prescription medications more affordable for Nevada's citizens. In addition to assessing the current status of these efforts, the overview will serve as a foundation on which to build in the future.

The initiatives will be discussed by the major purchasing groups in Nevada: Nevada Division of Health Care Financing and Policy (Medicaid), Nevada Mental Health and Developmental Services Division, State Pharmacy Assistance Programs (Senior Rx and Disability Rx), Public Employees Benefit System (PEBS), Nevada Department of Corrections and counties. A status update on the Canadian pharmacy mail order service is also included. A brief overview of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) is included due to the impact this legislation has on all drug purchasing systems.

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

Nevada Medicaid covers approximately 98,000 lives under the Fee-for-Service plan and approximately 82,000 lives under the Managed Care plans. For Nevada, a majority of the drug expenditures are within the eligibility categories for the Aged, Blind and Disabled (ABD). The Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) Medicaid categories have lower drug expenditures than the ABD groups. Pharmacy coverage for TANF and CHAP recipients is provided primarily through Medicaid Managed Care plans.

Pharmacy services are covered under the federal regulations as an optional program. In order for Nevada Medicaid to receive federal funding for this program specific criteria must be met. These are described in section 1927 of the Social Security Act. One important criterion is that the state must offer an open formulary. This means that all FDA approved drugs are covered with a few exceptions. The exceptions are weight loss drugs, fertility drugs, experimental drugs, and drugs that are offered by a drug manufacturer that does not participate in the federal drug rebate program. The federal Medicaid drug rebate program was authorized by Congress under the Omnibus Budget Reconciliation Act (OBRA) of 1990.

This paper will outline the initiatives and current status for the Nevada Medicaid's Fee-for-Service pharmacy program.

Expenditure Profile

Medicaid Pharmacy expenditures totaled over $163 million in SFY2005. The pattern of these expenditures varies considerably across aid categories. ABD recipients comprise only 26% of the total Medicaid caseload, but comprise 70% of total prescription drug expenses.

By contrast, the TANF/CHAP Aid Categories represent 68% of the Medicaid caseload, but account for only 16% of total pharmacy expenditures. Within the TANF/CHAP population, approximately 73% are enrolled in a Managed Care plan, yet these recipients represent only 59% of the TANF/CHAP pharmacy costs. Division staff are currently reviewing the low rate of pharmacy utilization by TANF/CHAP recipients in managed care programs compared to fee-for-service utilization.

ABD plus TANF/CHAP pharmacy expenditures represents 86% of the total Medicaid pharmacy expenditure. The remaining 14% of Medicaid pharmacy expenditures in SFY2005 were distributed among recipients enrolled in home and community based programs, the Breast and Cervical Cancer coverage group, Child Welfare, and County Match Aid Categories.

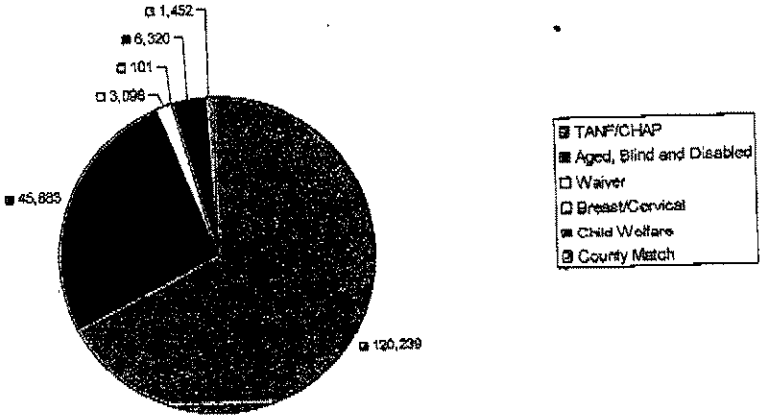
MEDICAID CASELOAD AND PHARMACY EXPENDITURE DATA BY AID CATEGORY

	2004	2005	2006	2007
TANF/CHAP (FFS + HMO)	$23,985,916	$26,369,182	$30,060,310	$34,621,908
AGED, BLIND, DISABLED	$97,954,812	$114,302,527	$132,847,076	$153,957,204
WAIVER	$9,714,308	$12,249,235	$15,974,092	$18,728,410
BREAST/CERVICAL CANCER	$185,679	$180,177	$197,470	$204,200
CHILD WELFARE	$4,321,757	$5,907,407	$6,738,928	$7,632,365
COUNTY MATCH	$3,986,381	$4,790,341	$5,285,257	$5,880,336
PHARMACY TOTAL	**$140,148,853**	**$163,818,869**	**$191,103,133**	**$221,024,423**
TOTAL MEDICAL EXPENDITURES	**$829,881,772**	**$892,801,266**	**$964,261,500**	**$1,053,427,706**

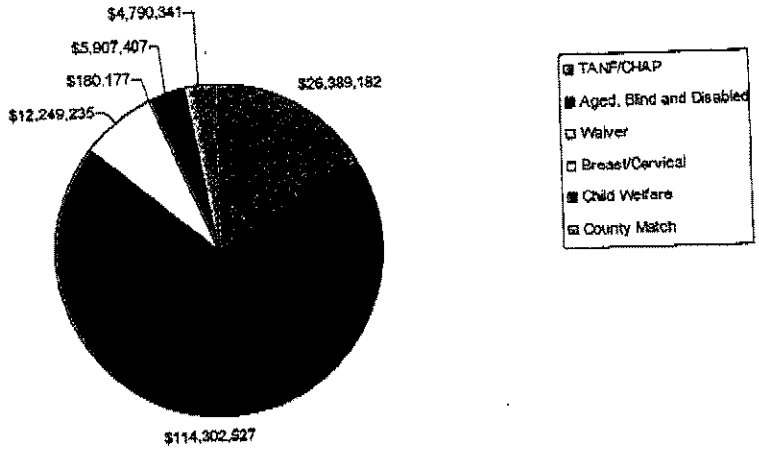
AVERAGE MONTHLY CASELOAD SUMMARY[1]				
	2004	2005	2006	2007
TANF/CHAP (FFS + HMO)	119,408	120,239	125,036	131,693
AGED, BLIND, DISABLED	44,120	45,883	47,519	49,825
WAIVER	2,759	3,098	3,582	3,787
BREAST/CERVICAL CANCER	104	101	110	114
CHILD WELFARE	5,222	6,320	6,342	6,478
COUNTY MATCH	1,346	1,452	1,435	1,442
TOTAL	172,959	177,093	184,024	193,339

[1]Caseload data is from the 2005-2007 DHR/DHCFP Legislatively Approved MPP Caseload Summary, April 1, 2005.

2005 Medicaid Caseload Summary by Aid Category



2005 Medicaid Pharmacy Expenditures by Aid Category



Administrative Services

The Nevada Medicaid Pharmacy program employs one full-time state staff person to oversee the pharmacy program's policies, procedures, service implementation, and contract oversight.

A Medicaid Fiscal Agent contract was awarded in October 2002. Part of the contract was implementation of a Point-of-Sale (POS) pharmacy claims adjudication system. The contractor provides the state with clinical guidance, facilitation, clinical review and implementation of initiatives within the pharmacy program. The pharmacy programs under this contract include Prospective Drug Use Review (ProDUR), Retrospective Drug Use Review (RetroDUR), OBRA Rebate program, pharmacy claims adjudication, facilitation of the federally required Drug Use Review (DUR) Board, provider education and outreach, recipient education and outreach, and system reporting requirements.

In August 2003, Nevada Medicaid awarded a Prescription Drug Management Program contract. This contract is for the development, implementation, and maintenance of a Preferred Drug List (PDL), Supplemental Rebate Program, Multi-state purchasing program, support for the Medicaid Pharmacy and Therapeutics (P&T) Committee, Maximum Allowable Cost (MAC) schedule, provider education and outreach, and reporting requirements.

In 2003, Assembly Bill 384 added administrative restrictions to the pharmacy program. Under Nevada Revised Statutes (NRS) 422.201-422.406, the Nevada Medicaid program is restricted from placing the following therapeutic classes of drugs on the PDL. The exempt classes are atypical and typical anti-psychotics, human immunodeficiency virus or acquired immunodeficiency syndrome, anticonvulsant medications, anti-rejection medications, and any drugs the P&T Committee chooses to eliminate from the PDL. The NRS also requires that the DUR Board not consider costs when developing clinical step therapy protocols and that the P&T Committee not consider costs when developing the PDL.

The following information provides a more detailed description of the steps that Nevada Medicaid and Nevada Check Up have taken to contain the ongoing increase in pharmacy expenditures experienced by every purchaser in the health care market.

Ingredient Reimbursement

In July 2002, Nevada Medicaid, through a public process, changed the reimbursement for the ingredients of outpatient pharmaceuticals from Average Wholesale Price (AWP) less 10% to AWP less 15%.

The dispensing fee is $4.76 per prescription for outpatient pharmaceuticals, $22.40 a day for antibiotic infusion therapy provided in the home, and $11.20 a day for antibiotic infusion therapy while the recipient is in a nursing facility.

Preferred Drug List

In 2003, Nevada Medicaid and the contractor held multiple public workshops and hearings to establish the policies and procedures that would govern the PDL and the P&T Committee. Participants included the Retail Association of Nevada, National Association of Chain Drug Stores, Pharmaceutical Research and Manufacturers of America (PhRMA), Nevada Medicaid providers, and recipients. After the policies were agreed upon, Nevada Medicaid codified the policies into regulation.

The P&T Committee convened in February 2004 to begin establishing the PDL for Nevada Medicaid and Nevada Check Up. The P&T committee met on a monthly basis from February 2004 through August 2004, to review the clinical appropriateness and equivalency of approximately 30 therapeutic classes. The realized goal of the P&T was to exercise sound clinical judgment in the review and recommendation process.

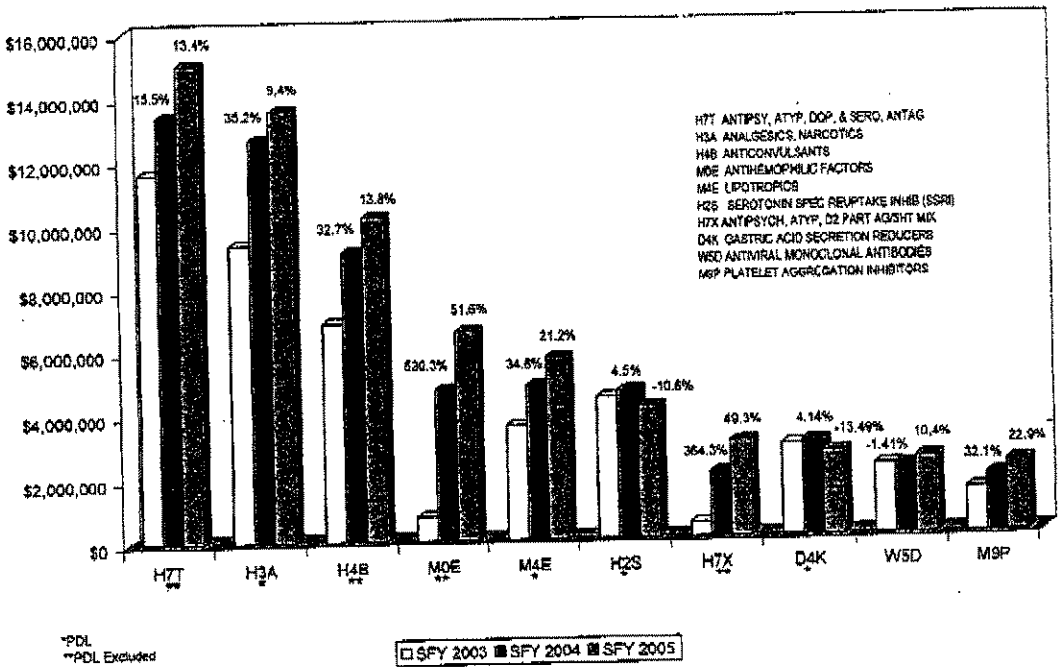
The P&T Committee continues to hear public testimony on each of the therapeutic classes. They review a class of drugs and decide if they are therapeutically equivalent. Once determined therapeutically equivalent, the contractor and Nevada Medicaid give the P&T Committee their recommendation of drugs to include on the PDL. The P&T Committee, independent of Medicaid or the contractor, decide which drugs will be included or excluded from the PDL.

Nevada Medicaid chose to implement the PDL using a phased approach over a two-month period. In order to assure successful implementation, the contractor met with key stakeholders and individual providers to educate them on the process surrounding the PDL.

The standard measurement of a successful PDL is the level of compliance by the prescribers with the drugs that are on the PDL. The Pharmacy call center statistics from May 2005 reflect a 48.2% change rate to drugs on the PDL. This number reflects the number of prescriptions that physicians changed to a drug that is on the PDL. As of the fourth quarter of CY 2004, prescribers were in 86.6% compliance with the PDL.

NRS 422 requires an annual review of the current PDL by the P&T Committee. In July 2005, the P&T Committee performed this review on all of the therapeutic classes listed on the current PDL. The current PDL may be found at https://nevada.fhsc.com/. An important note is that, of the top 10 highest-paid drugs for Nevada Medicaid, seven of the drugs cannot currently be added to the PDL due to NRS 422.

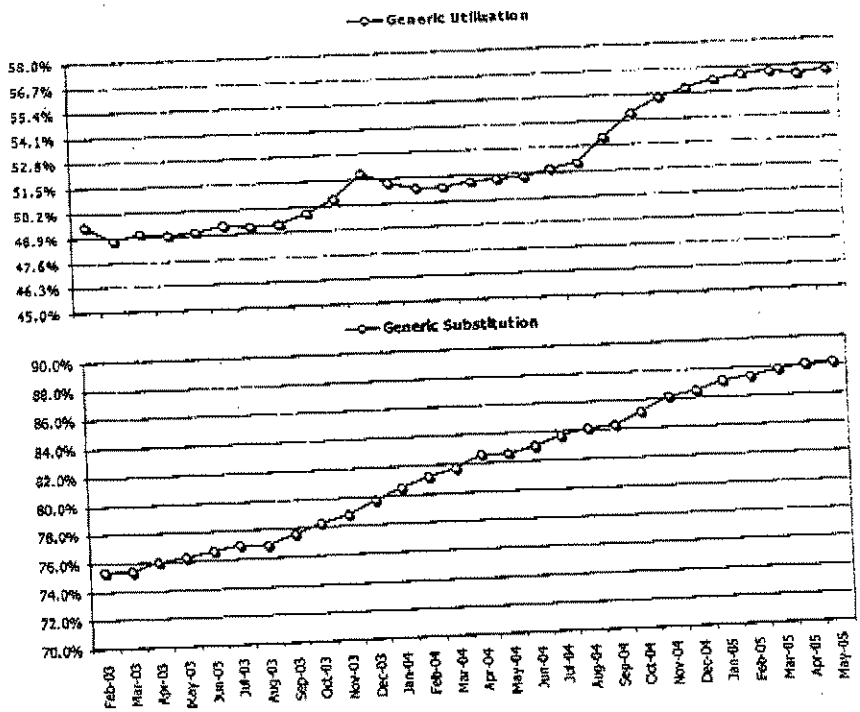
Top 10 Therapeutic Classes Ranked by Payment Amount
Three Year Comparison



Maximum Allowable Cost

The contractor worked collaboratively with Nevada Medicaid to implement the Maximum Allowable Cost (MAC) fee schedule in December of 2004. Nevada Medicaid also worked collaboratively with stakeholders through a public process to codify the policies into regulation. MAC is a Nevada Medicaid-specific pricing program for generic drugs. The MAC allows Nevada Medicaid to reimburse pharmacies at the lowest rate based upon comparable regional rates for the same type of generic drug.

The MAC fee schedule has been one of the most successful pharmacy initiatives implemented. Savings occur by shifting the use of name brand drugs to generic utilization and receiving a considerable discount on the ingredient costs of generic drugs. While Nevada has a state statute that requires the use of generic drugs when available, implementation of MAC has had a significant impact on the rate of generic drug use. After implementation of MAC in 2003, Nevada Medicaid increased generic utilization from 49.4% in February 2003 to 56.4% in May 2005. The generic substitution rate increased from 75.5% in February 2003 to 88.9% in May 2005.[1]



RetroDUR and ProDUR

Prospective Drug Use Review (ProDUR) is used to review the impacts of the dispensing of the drug prior to its dispensation. The Medicaid Pharmacy Point of Sale (POS) system, an online, real time system that reviews and adjudicates pharmacy claims, is the tool used for ProDUR. POS has multiple edits in place to prevent drug-to-drug

interactions, drug-to-disease interactions, drug-to-gender interactions, and over- and under-utilization of prescriptions. The process is a combination of both soft edits and hard edits. Soft edits are a message to the pharmacist that does not require any manual intervention. A hard edit requires the pharmacist to override the edit with specific clarification codes. Some hard edits require the pharmacist to call the clinical call center for override approval.

Each Medicaid pharmacy program is federally required to have a Retro Drug Use Review Board (DUR Board) to assure that covered outpatient drugs prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. The Board also focuses on education and outreach, fraud and abuse, and utilization patterns of prescriptions. The DUR Board utilizes previous drug utilization and claims history to develop interventions.

In July 2002, the DUR Board implemented the use of step therapy protocols for Proton Pump Inhibitors (gastric acid reducing medications such as Nexium), Cox II's (anti-inflammatory drugs such as Vioxx), and erectile dysfunction drugs (such as Viagra). Those initiatives substantially decreased the unnecessary prescribing of these drugs in favor of prescribing less expensive drugs that provide the same efficacy.

Over the last year, the DUR Board has focused on the implementation of several quantity limitations for specific long-acting narcotic, respiratory, anti-emetic, and anti-coagulant drugs for hemophiliac patients. Just recently, the DUR Board approved the ProDUR editing of severity level one interactions prior to the dispensing of the drug. Severity level one edits identify drug interactions that have a high risk of an adverse action if the drug is given to a specific recipient. Over the next year, the DUR Board plans to focus on reducing the inappropriate use of narcotic and antipsychotic medications.

Drug Rebates

The OBRA '90 Rebate program is the federal rebate offered to Medicaid programs for participating under §1927 of the Social Security Act. These rebates are offered to the states after the drugs have been reimbursed to the pharmacy. Prior to the POS system, Nevada Medicaid had a manual accounting system for collection of rebates; the rebate collection was less than 18%. Part of Nevada Medicaid's Fiscal Agent contract is to invoice, collect and handle dispute resolution with drug manufacturers for OBRA '90 rebates. The collection rate for OBRA '90 rebates now average 23.3% of rebateable drug spending. This equates to approximately $6.9 million for first quarter 2005.

Supplemental rebates are additional rebates offered by the manufacturers in addition to OBRA '90 rebates. The manufacturers have an incentive to provide the State with an attractive rebate amount which reduces the State's overall net price for that drug. The lowest cost equivalent drug in a class is often the product recommended to the P&T Committee for approval as a preferred drug on the PDL. If a drug is listed as preferred, the manufacturer can be confident that they will see a shift in market share to their

product. Currently, the supplemental rebate program is bringing in an additional 9.7% of rebates for Nevada Medicaid. This equates to approximately $600,000 for the first quarter of 2005.

National Medicaid Pooling Initiative

Under the Prescription Drug Management contract, Nevada Medicaid procured a national Medicaid purchasing pool manager. The following states are contractually involved with the National Medicaid Pooling Initiative (NMPI); Nevada, Tennessee, Vermont, New Hampshire, Alaska, Hawaii, Montana, Minnesota, and Kentucky. This pool represents over 2 million covered lives and over $2 billion in drug expenditures. The NMPI allows Nevada Medicaid to pool with other Medicaid programs to increase the number of lives the drug manufacturers are bidding on for best pricing for preferred drugs as well as to maximize supplemental rebates.

Overall Pharmacy Expenditure Information

Although pharmacy expenditures continue to increase, over the last several years the previously mentioned initiatives have decreased the rate of pharmacy expenditure growth. (Nevada Medicaid's fiscal agent estimates that, if Nevada Medicaid had not implemented any of the cost savings initiatives, the program expenditures would be an additional $30 million dollars.)

Other Considerations

Nevada Medicaid is continuing to assess the pharmacy benefit for opportunities to more effectively and efficiently manage utilization and expenditures. Over the next biennium, initiatives such as disease management for special populations, utilization of narcotics and anti-psychotics, and the impact of the Medicare Modernization Act will be considered in program planning and budget development.

NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

Minnesota Multi-State Contracting Alliance (MMCAP)

MHDS pharmacies in Nevada belong to the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). MMCAP is a consortium whose mission is to provide value via reduced costs and improved services to participating states and facilities through voluntary cooperative purchasing of pharmaceuticals and allied products and services.

- MMCAP has a consortium of 43 states and cities, including the City of Chicago.
- There are 4,507 participating facilities in the MMCAP.

- MMCAP maintains contracts for pharmaceuticals/over the counter drugs (OTCs), distributors, hospital and medical supplies, drug testing, influenza vaccine, vials/containers, returned goods processing, prescription filling, and oral contraceptives for student health centers.

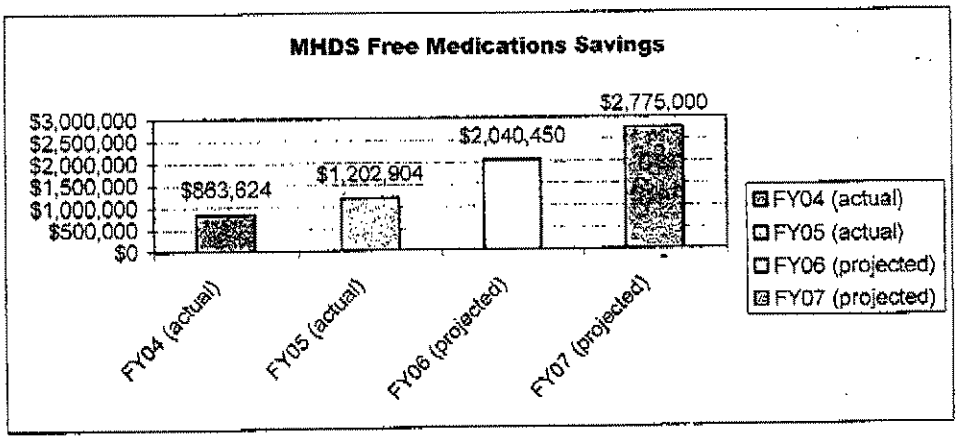
- There are three MMCAP national distributors. Along with 30 other states and one city, Nevada is associated with the distributor that holds an 82% market share ($573 million). Partners include Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Idaho, City of Chicago, Maine, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

- Through sheer effort of buying power, MMCAP realizes considerable savings in the purchase of pharmaceuticals by the participants. For example, over the last contract year and considering the top 100 sole-source pharmaceuticals which equal 57.75% of total purchases, 1.84% discount from WAC (weighted average cost) was realized. This translated to a savings of $11,143,770 from WAC. With regard to the top 100 multi-source pharmaceuticals which equal 9.34% of total purchases, 22.62% discount from WAC was realized. This translated to a savings of $28,319,674 from WAC. Concerning the top 200 units x volume pharmaceuticals which equal 50.76% of total purchases, 7.29% discount from WAC was realized. This translated to a savings of $41,425,254 from WAC. Thus, a total savings of $80,888,697 from WAC was realized over the last year with top pharmaceutical items. By procedure, after deducting the 1.5% administrative fee to MMCAP to cover the cost of operating the program, any excess savings are credited back to the participants through the wholesaler in December of each year.

Free Medications

Free medications from manufacturers, which include drug samples, drug scholarship programs and patient assistance programs, are utilized to subsidize the drug budget. Nevada's Rural Clinics rely heavily on these programs to remain buoyant in fiscal management. The savings in these programs for FY04 and FY05 were as follows:

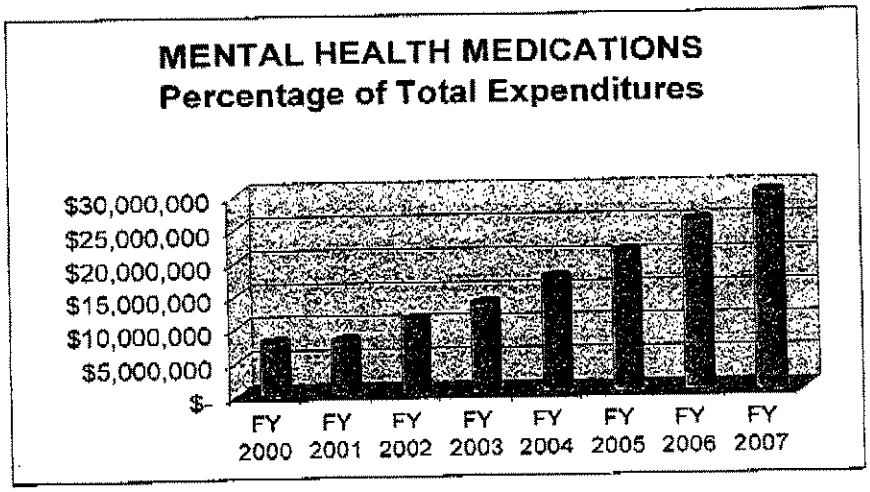
Rural Clinics	$447,712 (FY04), $750,440 (FY05)
Mental Health South	$235,787 (FY04), $267,509 (FY05)
Mental Health North	$180,125 (FY04), $184,950 (FY05)



MHDS agencies have started a more aggressive enrollment of qualified clients into the Patient Assistance Program at Southern Nevada Adult Mental Health Services. Plans are to integrate this program at Northern Nevada Adult Mental Health Services. The number of enrollees continues to rise, and the projected impact is to eclipse the $2 million dollar mark in resultant savings in FY06. The goal is to increase savings to about $3 million by FY07.

MENTAL HEALTH AND DEVELOPMENTAL SERVICES: MENTAL HEALTH MEDICATIONS
FY2000 - FY2007

FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
$7,837,215	$7,881,849	$11,018,724	$13,373,628	$17,076,890	$20,856,546	$25,335,133	$29,464,483
14.20%	13.29%	14.90%	17.85%	18.55%	20.70%	20.32%	19.16%



STATE PHARMACY ASSISTANCE PROGRAMS: SENIOR RX AND DISABILITY RX

The Senior Rx Program was established by Governor Guinn and the 1999 Legislature using Tobacco Settlement funds. Originally, the program provided prescription drug benefits through private insurance. As of January 1, 2005, the program was converted to a State-administered program with a contracted pharmacy benefits manager (PBM). The program had 8,812 members at the end of SFY 05 and spent $11,156,442 for medication expenses (the cost share paid by the State was $7,108,636 and members paid $4,047,806).

Under the new contract, a number of cost-saving measures were initiated. These include lower dispensing fees, lower PBM fee, larger discounts on the average wholesale price (AWP), and drug rebates. The new contractor also utilizes a Pharmacy and Therapeutics (P&T) Committee.

SENIOR Rx PROGRAM COST COMPARISON

OLD CONTRACT	CURRENT CONTRACT (Effective 1/1/05)
Drug Costs & Dispensing Fee ❖ $51.68 - $62.94 PMPM in FY04 ❖ Dispensing Fee = Approximately $2.16/Rx (50¢ Mail / $2.25 Retail) ❖ No Rebates to State	**Drug Costs & Dispensing Fee** ❖ PMPM Based on Formulary/Utilization/Inflation ❖ Lower Dispensing Fees – $ .50 Mail – $1.70 Generic – $2.00 Brand ❖ State will get Rebates – At least $2.00/Rx
Insured Product ❖ $14.86 PMPM – Insurance Costs – Insurance Prem. Taxes – PBM Fees – Administrative Costs	**Pharmacy Benefits Manager (PBM)** ❖ Significantly Lower PBM Fee – $1.00 (2006) – $ .90 (2007) – $ .81 (2008)
Discounts ❖ Mail / Brand.....20% off AWP ❖ Mail / Generics....50% off AWP ❖ Retail / Brand.....14% off AWP ❖ Retail / Generics...14% off AWP	**Discounts** ❖ Mail / Brand.....23% off AWP ❖ Mail / Generics....55% off AWP ❖ Retail / Brand.....15% off AWP ❖ Retail / Generics...15% off AWP

In SFY 05, the Senior Rx Program was able to enroll members into the drug discount card benefit under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Eligible members were able to receive $600 in drug benefits in CY 04 and CY 05. For the first six months of CY 05, members utilized more than $124,200 in federal benefits, creating a savings for Senior Rx.

In January 2006, Disability Rx, funded by Tobacco Settlement money, will begin serving people with disabilities under the age of 62. This program will mirror the Senior Rx Program and utilize the same PBM.

Both programs will provide supplemental "wrap-around" benefits to the new Medicare Part D program. By coordinating benefits with Part D, the state programs will maximize federal funding and avoid duplication of benefits, thereby saving state funds to expand or enhance services. These wrap-around benefits will be designed so that, under the new program, the typical utilizing Senior Rx member is "no worse off" with regard to out-of-pocket prescription expenses.

PUBLIC EMPLOYEES BENEFIT SYSTEM

Agency and Benefit Plan History

The Public Employees' Benefits Program (PEBP) administers the health insurance program for over 34,000 State of Nevada active employees and retirees and non-state active employees and retirees. Of the 34,000, approximately 25,000 participate in the PEBP self-funded PPO plan and 9,000 participate under one of the HMO options.

The PEBP self-funded PPO plan offers a comprehensive health insurance plan that includes medical, prescription drug, dental and vision coverage as well as life and accident insurance, long-term disability insurance, business travel accident insurance, and voluntary insurance for additional life, short-term disability and long-term care.

The total claim cost for the self-funded PPO plan in fiscal year 2005 for medical, prescription drug, dental and vision benefits was $135 million. Of that, $21 million or 16% was for the cost of providing prescription medication benefits.

Over the past four years PEBP has made numerous changes to the prescription drug benefit. Those changes are outlined below. As with many other health insurance plans, PEBP has had to modify its prescription drug benefit to keep pace with the ever increasing cost of prescription drugs.

Plan Year 2001 – The pharmacy plan implemented a co-payment system for retail prescriptions. Generic medications were available for $9 and name brand medications for $18. The mail order generic medication co-payment was increased from $15 to $25. Mail order name brand medication co-payment was increased from $25 to $50. The $25 calendar year deductible was eliminated.

Plan Year 2002 – Administered by the pharmacy plan changed to a three-tier program. The third tier was added to discourage the utilization of more expensive name brand medications. Preferred name brand drugs have a lower co-payment, therefore encouraging participants to become more knowledgeable about their medications and, with the assistance of their physician, select an equivalent alternative. In 2002, the mail order program was changed drastically. As part of the medical management program, certain drug categories were eliminated from the mail order drug list and made available through the retail program only. The medications in these categories are more commonly used on an as-needed basis and are not usually prescribed for daily long-term treatment of an illness.

Plan Year 2003 – No changes were made to the prescription drug benefit.

Plan Year 2004 – In 2004, PEBP made some very significant changes to prescription drug benefits. First, PEBP implemented an annual deductible of $50 per covered participant. And, in an effort to direct participants to use generic drugs, PEBP decreased the mail order drug co-payment from $15 to $5. In addition, PEBP increased the preferred brand retail drug co-payment from $22 to $40 for a 30-day supply and the preferred brand mail order drug co-payment from $55 to $70 for a 90-day supply. Finally, non-preferred drugs were classified as "non-formulary" and excluded from coverage including deductible credit.

Plan Year 2005 – The most significant change in Plan Year 2005 affected specialty drugs also known as self-injectable medications. In prior years, specialty drugs such as Avonex, Remicade and Enbrel were available through the mail order program and subject to the applicable mail order co-payment. In an effort to monitor the utilization of these very expensive medications, PEBP removed specialty drugs from the mail order program and restricted them to the retail drug program with mandatory purchase through PEBP's PPO specialty drug pharmacy, Walgreens. In addition, every participant receiving these types of medications is also eligible for individual case management services. The primary purpose for this change was to prepare for the introduction of many more biopharmaceutical therapies. With the introduction of these high-cost medications and the complexities of managing the diseases they treat, their complex administration methods, strict compliance requirements, special storage, special handling and delivery requirements and the potential side effects, it is important to closely monitor the unique challenges these therapies present. One of the several ways to monitor the utilization of these medications was to limit the dispensing to 30 days rather than 90 days.

NEVADA DEPARTMENT OF CORRECTIONS, MEDICAL DIVISION

The Nevada Department of Corrections (NDOC) has approximately 11,400 inmates in 19 facilities around the state. The Department has two pharmacies that service the northern and southern regions, respectively. In FY05, $3,829,562 was spent on medications for the inmate population. In an effort to mitigate the rising cost of drugs, the following steps or programs have been instituted.

Membership in the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP)

MMCAP is a voluntary group purchasing organization operated by the State of Minnesota serving government-operated healthcare facilities. The goal of MMCAP is to provide member organizations the combined purchasing power to receive the best prices available for pharmaceuticals, hospital supplies, and related products. As mentioned previously in the Mental Health and Developmental Services subsection, the State of Nevada is one of 43 participating states/cities. The MMCAP utilizes exclusive distributors and all purchases are made utilizing MMCAP pricing. The only exceptions would be when an out-of-stock situation exists for an MMCAP participating vendor or when a lower priced equivalent is available. Any exceptions are documented and the documentation is sent to State Purchasing.

Establishment of NDOC Drug Formulary

NDOC has established a formulary of 270 approved medications for use in health care treatment of inmates. The formulary is composed of generic and proprietary medications. For instances where the physician feels a medication not listed on the formulary should be used, a Non-Formulary Request is sent to the Pharmacy and Therapeutics (P&T) Committee for consideration.

Establishment of Pharmacy and Therapeutics Committee (P&T Committee)

NDOC has established a P&T committee, chaired by the Chief Pharmacist, comprised of physicians, pharmacists, nurses and administrators to set drug policy and review drug utilization, non-formulary requests and drug algorithms. Drug algorithms are drug therapy courses of action that start patients on less costly drugs and progress them to newer, more expensive drugs only if warranted.

CLARK COUNTY SOCIAL SERVICE

Clark County Social Service pays pharmacy costs for eligible indigent clients. In an effort to reduce costs, the county has contracted with a pharmacy benefit management company (PBM), to process client pharmacy billings.

The PBM has been operational for almost a full fiscal year. Straight pharmacy billings and, recently, COBRA co-pays have been processed through the system. The total gross billings through the PBM are $14 million for both programs, $12.5 million of which is the billing for University Medical Center (UMC) alone. Both programs processed more than 80,000 individual transactions. The administrative rate per claim is $0.30. However, rebates have offset that amount. The PBM has provided a contractual guarantee that the County will not pay a penny toward the administrative rate even if the rebate "credits" are less than the total administrative charges. In addition, the cost of

processing has decreased because 80,000 individual client transactions have been reduced to a total of 120 PBM transactions per fiscal year.

Besides the savings in labor costs, the program ensures that the rates paid are correct and also handles the third party billing with the COBRA program. The PBM can negotiate rates or, as in the County's case, pre-set the rates. Detailed reports show usage and frequency of drugs, which can allow the PBM to set limits on refills and monitor double billings and daily prescription issuance. Additionally, the PBM can establish formularies and restrictions on types or quantities of drugs allowed for each of the programs.

The largest potential savings is in the ability of the PBM system to encourage and monitor the usage of generic drugs. The detailed reports available for analysis list each drug paid by type, including the percentage of generic drugs used. This list is available by doctor or issuing pharmacy, and can be used to take corrective action based on usage.

At minimum, Clark County is saving substantial labor hours of processing time. Additionally, the use of the PBM will enable the development of formularies to control the costs of medications, such as by limiting brand name drug usage and setting firm prices on other items. Prior to contracting with a PBM, the County was not able to ensure billings were reimbursed at the proper rate. It was also very labor intensive to correct the rates on the individual bills. Overall, the use of a PBM has not cost any out-of-pocket expenses, and the potential savings are significant based on the total $14 million volume.

WASHOE COUNTY SOCIAL SERVICES

Washoe County Social Services pays pharmacy costs for eligible indigent clients that are accepted for nursing home and hospital based freestanding clinics.

There are approximately 17 ongoing nursing home clients with pharmacy costs averaging $289.32 per month for a total annual cost of $59,021. The County uses First Data Bank software, which is a federal database of drugs listing the NDC code, the drug name and the average wholesale price (AWP). Washoe County reimburses the nursing home contracted pharmacies at AWP minus 10%. Previous to this change, the county reimbursed 100% of billed charges

Washoe County Clinic eligible patients are billed monthly by the area hospitals. The pharmacy charges are included with their office visits. Billing clerks monitor for duplicate billing, over-the-counter medications, and prescription drug quantity.

Washoe County Social Services works closely with the Washoe Medical Clinic Pharmacist and uses an approved formulary drug list. Any non-formulary drugs are reviewed by the pharmacy staff for necessity.

In the clinic setting, Washoe County eligible clients are required to pursue the Patient Assistance Program, where pharmaceutical companies subsidize certain drugs based on income eligibility. This program provided $2,153,938.43 in medications to clinic patients. The cost to the County was a minimal administrative cost. The pharmacy staff also monitors pain medication usage and requires that all pain patients sign a Pain Contract.

Washoe County has engaged a contractor for FY 05-06 to perform utilization review on County eligible clients who are receiving prescriptions through the Washoe Medical Center Clinic. The new Medicare Part D medication review guidelines will be used.

STATUS UPDATE ON LICENSURE OF CANADIAN PHARMACIES

In the 2005 Special Session, Senate Bill 5 granted the Nevada Board of Pharmacy the authority to license Canadian pharmacies to provide prescription drugs through mail order service to residents of Nevada. This bill also requires the Office for Consumer Health Assistance to establish and maintain a website to provide information to consumers concerning purchasing prescriptions from approved Canadian pharmacies.

The Board of Pharmacy has received 10 applications from Canadian pharmacies seeking licensure in the State of Nevada. Each pharmacy is required to sign certain acknowledgements that ensure compliance with the Nevada Revised Statutes. A physical inspection is conducted of each Canadian pharmacy requesting licensure and meeting the requirements set by the Board. If the result of the pharmacy inspection is satisfactory, the pharmacy is considered for licensure at the next Board meeting. Upon approval by the Board, information about a licensed Canadian pharmacy is transmitted to the Governor's Office for Consumer Health Assistance for inclusion on its website.

GOVERNOR'S OFFICE FOR CONSUMER HEALTH ASSISTANCE

The Governor's Office for Consumer Health Assistance maintains an online consumer resource that helps connect Nevada consumers without prescription drug coverage to the medicines they need. The website asks basic eligibility questions, then compares the information against a database of patient assistance programs operated by pharmaceutical companies, state agencies, and foundations. Individuals are connected to the programs that most closely fit their unique criteria. The web address is www.RxHelp4NV.org.

Attendee List 9-15-05

Last Name	First Name	Position	Company Name	Representative
Bond	Bobbett	Manager, Gov. & Community Affairs	Culinary Welfare Fund	
Brandenburg, Ph.D.	Carlos	Administrator	MHDS	<Staff>
Buckley	Barbara	Assembly Member	Nevada State Assembly	(Legislator-A)
Campbell	Chris	Executive Director of Corporate Ben	MGM Mirage Corporate Benefits	
Cegavske	Barbara	Senator	Nevada State Senate	(Legislator-S)
Clark	Thelma	President	Silver Haired Forum	
Combs	Rick	Program Analyst	LCB	<Staff>
Countryman	Jane	Executive Assistant	DHHS	<Staff>
Crawford	Daryl		Inter-Tribal Council of Nevada	
Davis	Vic	President	NAMI	
Davis Hoggard	Verlia	President	Silver Hair Legislative Forum	
Desruisseaux	Robert	Chair	Disability Strategic Plan Committee	
Dimmitt	Barbara	Senior Research Analyst	Legislative Counsel Bureau	<Staff>
Domenici	Lona	Coordinator	LCB/NV Silver Haired Legislative F	<Staff>
Duarte	Charles	Administrator	Department of Health and Human Se	<Staff>
Ebo, Pharm. -D.	Emmanuel	State Pharmacy Director	Department of Health and Human Se	<Staff>
England	David	Chair	Drug Utilization Review Board	

Last Name	First Name	Position	Company Name	Representative
Evilsizer	Mary		Centers for Independent Living	
Florence	Myla		Aging Commission	
Frederick	Sharon		Tribal Representative	
Gold	Barry		AARP	[AARP]
Gross	David			(Speaker)
Guinn	Kenny			(Speaker)
Haartz	Alex	Administrator	Health	<Staff>
Hanson	Karmen			(Speaker)
Heck	Joe	Senator	Nevada State Senate	(Legislator-S)
Henshaw	Ilene	Senior Legislative Representative	AARP-SNI-State Affairs	[AARP]
Horsford	Steven	Senator	Nevada State Senate	(Legislator-S)
Koivisto	Ellen	Assembly Member	Nevada State Assembly	(Legislator-A)
Krause	Brendan			(Speaker)
Lawrence	Coleen		DHCFP	<Staff>
Liveratti	Mary	Deputy Director	Nevada Department of Health and H	<Staff>
Luehrs	John			(Speaker)
Lyons	Marsheilah	Sr. Research Analyst	Legislative Counsel Bureau	<Staff>
Mabey	Garn	Assembly Member	Nevada State Assembly	(Legislator-A)
Marlowe	Dale			[AARP]
Martin	Darryl	Director	Clark County Social Services	

Last Name	First Name	Position	Company Name	Representative
Matheis	Lawrence	Executive Director	Nevada State Medical Association	
Mathews	Bernice	Senator	Nevada State Senate	(Legislator-S)
McClain	Kathy	Assembly Member	Nevada State Assembly	(Legislator-A)
Miller	Rich	Vice President		For Scott Watts
Moore	Deborah		AARP	[AARP]
Olson	Laurie	Managment Analyst IV	Department of Health and Human Se	<Staff>
Phillips	Steven	Chair	Pharmacy & Therapeutics Committee	
Pinson	Larry	Director	State Board of Pharmacy	
Ready	Elizabeth			(Speaker)
Rengert	Marlene	Nevada State President	AARP	[AARP]
Retterath	Ken	Dir. Adult Svcs Div.	Washoe Co. Social Services	For Mike Capello
Rhodes	Susan	Chair	Senior Strategic Plan Committee	
Sala	Carol	Administrator	Department of Health and Human Se	<Staff>
Saxl	Mike	Consultant	Maine Street Solutions	[AARP]
Schondelmeyer	Steve			(Speaker)
Sloan	Carla			[AARP]
Takumi	Roy			(Speaker)
Thorne	Forrest P.	Director	Public Employee Benefits Program	
Townsend	Randolph J.	Senator	Nevada State Senate	(Legislator-S)
Walsh	Jude			(Speaker)

Last Name	First Name	Position	Company Name	Representative
Washington	Maurice E.	Senator	Nevada State Senate	(Legislator-S)
Weber	Valerie	Assembly Member	Nevada State Assembly	(Legislator-A)
Wherry	Mary	Deputy Administrator	DHCFP/Medicaid	<Staff>
Willden	Mike	Director	Department of Health and Human Se	<Staff>